2. Eligibility

2.1 Medicaid Eligibility for the Aged, Blind, and Disabled

Medicaid is a Federal and State funded health care program that pays for medical services provided to individuals who meet specific eligibility requirements (listed below). The program serves families, children, pregnant women, senior citizens, persons with disabilities, and persons who are blind.

Recipients of services under the Support Services Waiver will meet Medicaid eligibility under the "Aged, Blind and Disabled" category. (Local Division of Family and Children (DFC) offices are responsible for the determination and redeterminations of eligibility for Medicaid.

Applications are filed with the local DFC in the county where the applicant lives. *An individual has the right to apply for Medicaid without delay or discrimination and to receive written notice of the eligibility determination.* Medicaid eligibility may be retroactive up to three months prior to the month in which the application was received by the local DFC.*

An individual has the right to appeal any action taken with regard to his/her eligibility for Medicaid. To file an appeal, a written request for a fair hearing must be sent to the local Office of Family and Children or to the Hearings and Appeals Section, Family and Social Services Administration.

To be eligible for Medicaid as an individual who is aged, blind or disabled, the individual must meet: categorical; non-financial; and financial eligibility requirements.

2.1.1. Categorical Eligibility

The following three categories receive the full range of Medicaid services. (Financial/non-financial eligibility must also be met.)

- Aged - Age 65 and older.

* If at the time of application, a waiver applicant is not a Medicaid recipient, case management may not be billed to Medicaid. Medicaid may be billed at a later date, if the applicant is determined to be eligible for Medicaid and the Medicaid effective date is retroactive to at least the date of the waiver application.

- Blind - Generally stated, the definition of blindness in Indiana law is as follows: Central visual acuity of 20/200 or less in the better eye with correcting glasses, or a visual field contraction or no more than 20 degrees. Persons receiving Supplemental Security Income (SSI) due to blindness automatically meet this requirement.
- Disabled - Generally stated, the definition of disability in Indiana law is as follows: A physical or mental condition that appears reasonably certain to result in death or to last for a continuous period of at least four years without significant improvement, and which substantially impairs the person's ability to work in a useful occupation. Persons who are receiving SSI do *not* automatically meet this requirement.

2.1.2 Non-Financial Eligibility

If an individual fits into one of the previously listed categories, the following eligibility criteria must also be met:

- Must be a resident of Indiana;
- Must be a U.S. citizen or a non-citizen in an eligible immigration status. Except for refugees, parolees, and persons whose deportation is withheld, lawful immigrants who enter the country after August 22, 1996, are not eligible for full Medicaid coverage for 5 years. During that time, however, they may receive coverage for emergency medical care if they meet all other eligibility requirements. Additionally, immigrants who have no proof of legal residence in the U.S. are entitled to emergency services if other eligibility requirements are met;
- Must furnish his/her Social Security number;
- Must assign to the State all rights to medical support and payments for medical care that could be available from any third party such as insurance or a non-custodial parent. Individuals must cooperate in providing information about responsible third parties and obtaining third party payments and medical support, unless the individual establishes good cause for not complying.

2.1.3. Financial Eligibility

Financial eligibility is based on the income and resources/assets of the individual and his or her spouse.

2.1.3.1 Income

Income limits increase in January of each year based on the Social Security cost of living adjustment (COLA). "Countable" income from employment is calculated by subtracting $65 from the gross income and dividing by 2. If the applicant is a child, the income and resources of the child's parents are counted unless the child is receiving services under a Home and Community-Based Services Waiver.

2.1.3.2 Resources

For the Aged, Blind, and Disabled categories the resource limits are:

- $1500 Individual; one parent of a child applicant
- $2250 Married couple; two parents of a child applicant

There are many kinds of resources that are not counted: the home; irrevocable funeral trusts; income-producing real estate; real estate that is used to produce food for home consumption; real estate that is being offered for sale or rent at fair market value; resources that were protected by purchasing and using an Indiana partnership long term care insurance policy; and, in most cases, one car. Resources that count include: checking and savings accounts, certificates of deposits, stocks, bonds, and the cash value of most life insurance policies.

2.1.3.3 Spend-Down

FSSA has made a significant change in the post-eligibility treatment of income in the Support Services Waiver. States may choose to extend Medicaid eligibility to waiver applicants who have gross income as high as 300% of the maximum SSI benefit. Persons who are eligible under the 300% option, typically pay a share of their income toward the cost of their care. This "spend-down" amount is determined by subtracting a maintenance allowance (an amount protected for the

individual's personal use) from the total income. This protected amount covers such things as the individual's basic needs. State may choose to establish higher maintenance allowances for waiver participants eligible under the 300% option to assist individuals in covering their living expenses.

In the Support Service Waiver, Indiana will utilize the 300% rule and a more generous maintenance allowance, the result of which will be to greatly reduce (if not eliminate) the number of individuals on this waiver who must contribute to the cost of their Medicaid services.

2.1.3.4 Senate Bill 30

Senate Bill 30 (1991) is a provision which allows parental income and resources to be disregarded when determining Medicaid eligibility for children under age 18 who are in a Medicaid certified facility or being considered for a Medicaid HCBS waiver program in lieu of institutionalization. The exclusion of parental income and resources applies only as long as the child is a Medicaid waiver program participant. The inclusion of parental income in the determination of a child's eligibility for Medicaid resumes beginning the month following the month in which Medicaid waiver services are discontinued if the child continues to live with his/her parent(s).

2.2 Support Services Waiver Eligibility

Indiana has assured the Centers for Medicare and Medicaid Services that the following requirements for individuals who participate in a Home and Community-Based Waiver, are met:

2.2.1 Level of Care/Risk of Institutionalization

One of the requirements of the Social Security Act is that only individuals who would be at risk of institutionalization without the provision of home and community-based services, receive home and community-based services. An individual with a developmental disability must meet the criteria (the level of care) for placement in an Intermediate

Care Facility for the Mentally Retarded (ICF/MR) to be eligible for Support Services Waiver program participation.

2.2.2 Health and Safety

It must be determined that any program participant can be served safely in the community. This is accomplished in general, through Indiana's quality assurance program design and application, as well as through plan of care development and provider qualifications and training.

2.2.3 Cost Neutrality

Indiana must demonstrate that average per capita expenditures for the Support Services Waiver program participants are equal to or less than the average per capita expenditures of institutionalization for the same population.

2.2.4 Choice

When an individual is determined to be likely to require an ICF/MR level of care, he/she or the legal representative, must be informed of any feasible alternatives under the Waiver and given the choice of either institutional or home and community-based services.

2.3 Medicaid State Plan Services/Prior Authorization

Individuals who receive services under a Medicaid HCBS Waiver are also eligible to receive traditional services under the "regular" Medicaid program (State Plan services) such as physician services, medications, laboratory services, etc. Some services provided under the Support Services Waiver are also available under the State Plan. These services are: physical therapy, speech/language therapy, occupational therapy, psychological services, nursing services, dental services, special medical equipment, and transportation.

States have options in the amount, duration, and scope of the services that are provided under the State Plan. For example, physical therapy available under the State Plan must be authorized by Medicaid prior to its provision. Further, the amount, duration, and scope of the therapy will be limited to address a

specific acute condition. State Plan services are primarily restorative or remedial in nature and are not aimed at ameliorating a particular disabling condition. Therefore, it may be reasonable for a Support Services Waiver participant to receive physical therapy beyond what is available under the State Plan. If physical therapy is identified as a need on the individual's plan of care, and it has been documented that State Plan physical therapy is not appropriate or has been exhausted, the individual may receive physical therapy under the waiver.

2.4 Targeted Case Management

Indiana's Medicaid State Plan has been amended to include Targeted Case Management service for Indiana residents with developmental disabilities. An amendment to the Social Security Act allows states to waive the Act's requirement that any service offered by a state under Medicaid must be made available to all Medicaid recipients. The Centers for Medicare and Medicaid Services has waived this requirement for Indiana and is allowing the provision of case management under its State plan to "target" case management service to only persons on Medicaid who are developmentally disabled as defined under IC 12-7-2-61(2).

Although Supported Services Waiver recipients meet the requirements to receive Targeted Case Management, eligibility for case management for persons with developmental disabilities, is no longer tied to ICF/MR level of care/waiver eligibility. Individuals who do not meet level of care, but are Medicaid recipients who meet the state definition of developmental disability, may receive Targeted Case Mangement.

2.5 Hoosier Healthwise

Parents and children receiving Temporary Assistance for Needy Families (TANF) as well as non-TANF pregnant women and children with incomes at or just about the poverty level may choose to participate in Hoosier Healthwise.

The Hoosier Healthwise Program consists of:

- Primary Care Case Management
- Risk-Based Managed Care; and
- Managed Care for Persons with Disabilities.

Medicaid recipients are not allowed to enroll in both the HCBS Waiver Program and Hoosier Healthwise. They must choose one program or the other.

2.6 Hospice Services

Individuals who receive Medicaid Home and Community-Based Services and elect to use the Indiana Health Care Program Hospice benefit, do not have to disenroll from their waiver program, however, they must come under the direct care of the hospice provider for those services held in common by both programs. In short, the waiver member who elects the hospice benefit may still receive waiver services that are not related to the terminal condition and are not duplicative of hospice care. The hospice provider, targeted case manager, and the local Area Agency on Aging must collaborate and communicate regularly to ensure the best possible overall care to the Waiver/hospice member.